DWC-AD 10133.54
Request for Dispute Resolution Before the Administrative Director
For injuries occurring on or after 1/1/04

___Original ___Response

Has employer accepted this claim?
___ Yes ___ No
Has liability for injury been found by the WCAB?
___ Yes ___ No
Has it been more than 60 days since TTD ended?
___ Yes ___ No
Has PPD award been stipulated, issued/approved?
___ Yes ___ No

DWC Use Only

Social Security Number	**WCAB Number**	**DWC Unit Number**

Employee Name (Last) (First) (MI) Phone Date of Birth

Address (Street) (City) (State) (Zip)

Employer Name Phone	**Insurance Company Name; Or, if Self-Insured, Certificate Name**
Address	Adjusting Agency Name (if adjusted)
City, State, Zip	Claims Mailing Address
Date of Injury / **Claim Number**	City, State, Zip Phone No.
Employee Representative	**Employer Representative**
Firm Name	Firm Name
Address	Address
City, State, Zip Phone No.	City, State, Zip Phone No.

Vocational & Return to Work Counselor

Firm Name Representative Name

Address (Street, City, State, Zip Phone No.

The Administrative Director is requested to resolve the following dispute because the parties disagree on : (Please describe)

Summary of Parties' Informal Efforts to Resolve this Dispute	**Copies of this request with copies of pertinent documents have been served on:**
.	
Name of Requester **Date**	**Signature**

(Mandatory Form DWC-AD 10133.54 05/10/04)